SCDC POLICY/PROCEDURE

NUMBER: HS-18.07

TITLE: INMATE HEALTH RECORDS

ISSUE DATE: November 1, 2005

RESPONSIBLE AUTHORITY: MEDICAL AND HEALTH SERVICES

OPERATIONS MANUAL:HEALTH SERVICES

SUPERSEDES: HS-18.07 (August 1, 2003); Change 1 (3/29/04)

RELEVANT SCDC FORMS/SUPPLIES: 9-11, 19-11, 13-50, 13-52, M-13, M-16,

ACA/CAC STANDARDS: 4-ACRS-4C-22, 4-ACRS-4C-23, 4-ACRS-4C-24, 4-ACRS-7D-08, 3-4068, 3-4330, 3-4376, 3-4377, 3-4378, 3-4379, 4-4070

STATE/FEDERAL STATUTES: Section 24-1-130, Section 24-3-20,Section 44-115-80, South Carolina Code of Laws, 1976, as amended

SCDC MEDICAL DIRECTIVES: 100.A-4, 300.A-17, 500-11, 900.A-1, 900.A-4, 900.A-6,900.A-7, 900.A-9

PURPOSE: To provide guidelines for the development, maintenance, privacy, and security of electronic, paper, and oral protected health information.

POLICY STATEMENT: To promote consistency and accuracy, the Director of Health Services will appoint an interdisciplinary group of health professionals to a Documentation Standards Committee. This Committee will be tasked with developing guidelines for documenting information in an inmate's medical record. The Agency is committed to upholding the confidentiality and privacy of an inmate's medical history. Therefore, an inmate's medical history/record will be accessible to authorized SCDC personnel and others for duly authorized purposes only in accordance with applicable Agency policies/procedures, American Correctional Association Standards, and state and federal statutes. (4-ACRS-7D-08, 3-4068, 4-4070)

SPECIFIC PROCEDURES:

1.INMATE HEALTH/MEDICAL RECORDS:

1.1 The Documentation Standards Committee will be responsible for developing the Documentation Standards Guidelines. This committee will meet when changes to the Documentation Standards Guidelines are submitted. The Director of Health Services will have final approval of the Guidelines. Any deviation from these Guidelines may result in employee corrective action as outlined in SCDC Policy/Procedure ADM-11.04, "Employee Corrective Action."

1.2 The active medical health record will be kept in hard copy and/or via electronic media. Its format and content will follow the established Documentation Standards Guidelines. The Documentation Standards Guidelines will comply with related ACA Standards. (4-ACRS-4C-23, 3-4376)

1.3 Each employee who has access to protected health information will keep such information confidential. Each employee who has access to the Automated Medical Record (AMR) will be required to sign SCDC Form 13-52, "Automated Medical Record Computer and Information Usage Agreement." Employees who fail to follow the Agency's standards for protecting the security and confidentiality of protected health information will be subject to corrective action as outlined in SCDC Policy/Procedure ADM-11.04, "Employee Corrective Action."

1.4 Each clinic will have a copy of the Documentation Standards Guidelines for reference.

2.PRIVACY AND CONFIDENTIALITY OF MEDICAL/HEALTH RECORDS:

2.1 An inmate's health record is confidential. Access to an inmate's health record will be safeguarded by the Health Care Authority (HCA) and the medical staff of the applicable institution. The health record will be maintained separately from the confinement record and will be marked "CONFIDENTIAL." (4-ACRS-4C-22, 3-4377)

2.2 The Division of Resource Information Management will ensure that employees are only given access to the AMR whenapproval is provided on a properly executed SCDC Form 13-50, "CRT User Access Report Form."

3. RELEASE OF INFORMATION:

3.1 Protected health information may only be released to individuals other than the inmate by the Director of Health Information Resources (HIR) or designee. An administrative fee of sixty-five cents per page copied for the first thirty pages, fifty cents per page for any additional pages, and a clerical fee not to exceed $15.00 per request may be charged for copies of a health record. Health records will be provided at no charge to a physician or health care provider for continuation of treatment for a specific condition or conditions.

3.2 Information will be released upon receipt of a properly executed court order or subpoena. All court orders or subpoenas for inmate health records will be referred to the Director of HIR for processing within 24 hours of receipt or notification. Information will be released to the General Counsel's Office (or designee) upon request. (3-4378)

3.3 The HCA/designee will be permitted to share information with appropriate correctional authorities, on a need to know basis, regarding an inmate's medical management, security, and ability to participate in programs. If a non-medical staff member is given medical information about an inmate because of a particular need to know, e.g., post-exposure care, transportation, grievance, investigation, etc., that staff member must uphold the confidentiality of that medical information. (Refer to Medical Directive 900.A-7, "Internal Affairs Access to Health Records," for further details.) (3-4377)

3.4 Information regarding communicable diseases may be released by the Director of HIR or HCA/designee to a county health department or DHEC in accordance with state and federal laws.

3.5 When an inmate is referred to health care providers outside the SCDC, appropriate health information will be shared with those providers in accordance with consent requirements. (3-4330)

3.6 Information will be released to designated parties or agencies with a legitimate need for information (e.g., the inmate's attorney, a physician, including an elective outside medical care physician, a medical facility in the community, the Vocational Rehabilitation Department, or the Social Security Administration) by the Central HIR staff when the inmate provides his/her consent on SCDC Form 9-11, "Inmate/Resident Release of Information Consent" or a consent form provided by that agency or designated party. (3-4378)

3.7 When faxing or mailing protected health information to attorneys, medical review, outside physician's offices, etc., there should be a cover sheet with the following confidentiality statement:

"Note: The documents accompanying this facsimile transmission or mailing contain confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this facsimile in error, please notify the sender immediately to arrange for return of these documents."

3.8 When an inmate's immediate family member (spouse, father, mother, child) contacts SCDC staff with questions or concerns regarding health care issues, protected health information will only be shared upon receipt of a consent form signed by the inmate.

4. AN INMATE'S ACCESS TO HIS/HER OWN MEDICAL RECORD: An inmate's medical record belongs to the SCDC, but the information contained in the record may be made available to that inmate in accordance with the following guidelines: (See Medical Directive 900.A-6, "Inmate Access to His/Her Own Health Records," for specific guidelines.)

4.1 An inmate may make an appointment (using SCDC Form 19-11, "Request to Staff Member") with medical or medical records staff to review his/her health record and take notes in their presence. The inmate may view the AMR on the CRT screen in the presence of a medical staff member or the medical staff member may print appropriate portions for the inmate to view, at the discretion of that staff member. (This will exclude mental health information unless permission is given by the Division Director of Mental Health Services or designee. See Paragraph 4.2, below.) When the inmate has completed reviewing portions of his/her record printed from the AMR, the printed portions will be destroyed by the medical staff member.

4.2 An inmate may request to review portions of his/her psychiatric or psychological records using SCDC Form 19-11, "Request to Staff Member." These requests will be evaluated by the Division Director of Mental Health Services or designee before the inmate will be given an appointment to review the record in the presence of a Clinical Correctional Counselor.

4.3 An inmate may request a single copy of his/her HIV report and/or analytical eye record using SCDC Form 19-11, "Request to Staff Member." A copy will be made by the medical staff. The nurse will annotate the AMR to show that the inmate was given a copy of the HIV report and/or analytical eye record.

4.4 An inmate may request copies of his/her health record or portions thereof on SCDC Form 19-11, "Request to Staff Member." Each request will be forwarded to the Director of HIR or designee for evaluation on a case-by-case basis. If copies are made, the inmate will be charged an established fee of sixty-five cents per page copied for the first thirty pages, fifty cents per page for any additional pages, and a clerical fee not to exceed $15.00 per request.

5. REQUESTING INFORMATION FROM OUTSIDE PROVIDERS: If an inmate has been treated by a health care provider outside of the SCDC, before his incarceration, and the institutional physician feels the records from that provider will facilitate the inmate's continuity of care, Health Services staff will ask the inmate to sign SCDC Supply M-13, "Release of Medical Information to the South Carolina Department of Corrections," in order to obtain the records.~~In order to comply with the South Carolina Statutes 24-1-130 and 24-3-20 to provide for the custody, maintenance, health, welfare, education and rehabilitation of the inmates who have been given to the custody of the SCDC, inmate's medical records may be obtained by the SCDC without obtaining any authorization from the inmate. This is in compliance with S.C. Const. Art. Xii, 2., which states SCDC is the custodian of all its inmates and are entitled to access their medical records.~~ (Refer to Medical Directive 900.A-9, "Request for Information from Outside Providers," for further details.)

6. TRANSFER OF HEALTH RECORDS: An inmate's health record will be transferred when s/he is transferred from one area of medical coverage to another to ensure continuity of care. When permanent hard copies of medical records are transferred from one institution to another, appropriate CRT entries will be

made by both the sending and receiving institutional medical staff. The hard copy of the record will be transported in an envelope labeled "CONFIDENTIAL." (Refer to Medical Directive 900.A-4, "Transfer of Medical Records," for further details.)

6.1 Transfer to Another Institution When the Hard Copy of the Medical Record is Housed at the Same Location as the Inmate: If the hard copy of the medical record is housed at the same location as the inmate, all volumes will accompany the inmate when s/he is transferred to another institution. This includes all inmates transported via the Central Bus Terminal. The following will apply:

6.1.1 At institutions with 24 hour medical staff, or at all institutions when medical staff is present when the transfer occurs, the medical staff will obtain the record and prepare it for transfer, as per SCDC Medical Directive 300.A-17, "Continuity of Care." 6.1.2 At institutions that do not have 24 hour medical coverage and when no medical staff is on duty, the institutional operational staff will pull the inmate's medical record, package it in an envelope (marked "CONFIDENTIAL"), and label the envelope with the name of the receiving institution. Operations staff will ensure that medical staff is notified on medical's next working day that the inmate and his/her record were transferred. Medical staff will then make the appropriate CRT entries documenting the medical record transfer.
6.2 Transfer to Another Institution When the Hard Copy of the Medical Record is NOT Housed at the Same Location as the Inmate: If the hard copy of the medical record is not housed at the same location as the inmate (e.g., records housed at Central Office Building for inmates at Walden, Stevenson, Campbell, Watkins, etc.), all volumes will be sent through interdepartmental mail, packaged in an envelope (marked "CONFIDENTIAL") to the receiving institution. (NOTE: No action will need to be taken if transferring from one institution to another if both institutions' medical records are maintained in the Central Office Annex.)

6.3 Transfer to a Designated Facility: If an inmate transfers to a Designated Facility, his/her medical record will be transferred to the Central HIR office at the Central Office Annex.

6.4 Transfer for Outpatient Surgical Procedure: The original health record will not accompany an inmate to a community facility. If an inmate has outpatient surgery at a community facility, the medical record will stay at the inmate's assigned institution. After the procedure, the inmate will be given a post-op check by a physician at the assigned institution or an infirmary. The following will apply:

6.4.1 A copy of the consult for the procedure may be faxed to wherever the post-op check is anticipated, if not at the inmate's assigned institution.

6.4.2 The original consult will accompany the inmate to his/her procedure, along with pertinent copies of health information from his/her SCDC medical record.

6.4.3 After the surgery, the inmate and the original consult, with the community physician's recommendations on it, will be taken to the inmate's post-op check as outlined in SCDC Policy/Procedure HS-18.15, "Levels of Care."

6.4.4 The SCDC or contract physician will document his/her post-op evaluation and orders on SCDC Supply M-16, "Sick Call Clinic Notes," or on the AMR. The "Sick Call Clinic Note" and the consult will be filed in the medical record upon the inmate's return to his/her assigned institution. (4-ACRS-4C-24, 3-4378)

6.5 Transfers for Emergency Care:

6.5.1 SCDC Emergency Room (ER): When an inmate is transferred for emergency care within the Agency, the hard copy of the medical record will initially remain at the inmate's assigned institution. The ER medical staff will document their care in the AMR. If the inmate is admitted to the infirmary, the infirmary staff will request the hard copy of the medical record from the sending institution (may be the next working day, as appropriate). If the inmate is admitted to a community hospital, Procedure 6.5.2, below will apply.

6.5.2 Community ER: The hard copy of the medical record will initially remain at the inmate's assigned institution. The escorting Officer will request that the ER staff contact the appropriate infirmary staff for a disposition on whether the inmate may return to his/her institution, or whether s/he should be taken to the infirmary for a post-ER check. The escorting Officer will obtain emergency room paper work from the ER staff prior to transporting the inmate back to the appropriate SCDC institution. If a post-ER check is to be completed, the infirmary staff will request the hard copy of the medical record from the sending institution (if necessary). If the inmate is admitted to a community hospital, Procedure 6.7 through 6.7.4, below, will apply.

6.6 Transfer for In-patient Admission to an SCDC Infirmary: If an inmate is admitted to a SCDC infirmary, the charge nurse or designee will send the medical record with the inmate to the infirmary. The health record will accompany the inmate when s/he is discharged from the SCDC infirmary to return to his/her assigned institution. (4-ACRS-4C-24, 3-4378)

6.7 Admission to a Community Hospital:

6.7.1 The original health record will not accompany an inmate to a community facility. (4-ACRS-4C-24, 3-4378)

6.7.2 The hard copy of the medical record will be sent to the infirmary where the inmate's post-hospitalization check is anticipated, if not at the inmate's assigned institution. If the admission is an emergency admission after hours, the medical staff will send the medical record to that infirmary the next working day.

6.7.3 Upon the inmate's discharge from the hospital, the escorting officer will obtain the discharge paperwork prior to transporting the inmate to wherever his/her post-hospital evaluation is completed pursuant to SCDC Policy/Procedure HS-18.15, "Levels of Care.".

6.7.4 Post hospitalization evaluation:

•If the inmate is to return to his/her institution, the infirmary physician will document his/her post-hospitalization evaluation in the AMR. The discharge paperwork and hard copy of the medical record will be returned to the institution with the inmate.

•If the inmate is to be admitted into the infirmary, the hospital's discharge paperwork will be incorporated into the infirmary record. (4-ACRS-4C-24, 3-4378)

6.8 Transfer to Court:If an inmate transfers for a court hearing, the medical staff will review the record and send pertinent copies (e.g., Problem List, Medication Administration Record, etc.), as applicable, along with the inmate's medication. The original medical record will remain at the inmate's assigned institution. (Refer to Medical Directive 500-11, "Medications for Inmates Going to Court," for further details.) (3-4361)

7. INMATE DEATH: If an inmate death occurs, the charge nurse or designee will;

7.1 Notify the Central HIR office according to procedures outlines in SCDC Policy/Procedure HS-18.04, "Inmate Death."

7.2 If an autopsy is required, forward all appropriate volumes of the inmate's medical record, including the sick call notes documenting the incident and the current infirmary record, if applicable, to the contracting pathologist.

7.2.1 If the death occurs at the institution/infirmary, the medical record will be tagged according to Policy/Procedure HS-18.04, "Inmate Death." Institutional correctional staff will be responsible for transporting the medical record to the contracting pathologist. (The record may be transported packaged in an envelope (marked "CONFIDENTIAL") by the contract funeral home at the same time as the body.)

(NOTE: For those records that are on the AMR, the medical staff should print sick call notes for one [1] year prior to the inmate's death to accompany the hard copy of the record to the pathologist. If the pathologist requests that more AMR entries be forwarded to him/her, the Central HIR office will be responsible for compiling this information.)

7.2.2 If an inmate dies while housed at a Designated Facility, his/her medical record will be transported to the coroner by the Central HIR office staff.

7.2.3 If the death occurs in a community hospital, the institutional correctional staff will transport the record to the contracting pathologist. If the death occurs at a community hospital and the medical record is at an infirmary (other than the inmate's assigned institution), correctional staff at that infirmary will be responsible for transporting the medical record to the contracting pathologist.

7.2.4 Central HIR staff will be responsible for retrieving the record from the SCDC contract pathologist.

7.3 If an autopsy is not required, the inmate's complete medical record (including all volumes, infirmary and GPH charts) will be sent to the Central HIR office.

8. ESCAPE: In the event of an inmate escape, the medical record will be held in the inmate's assigned institution for five (5) days. If the inmate has not been apprehended after this time, his/her medical record will be sent to the central HIR office.

9. RELEASED INMATE: When an inmate is released, the medical record will be sent to the Central HIR office.

10. INACTIVE HEALTH RECORDS:

10.1 Inactive health records will be maintained by the Central HIR office in hard copy form for 25 years or on microfilm and/or on electronic media for 99 years. (3-4379)

10.2 If an Inmate Re-Enters the SCDC:

10.2.1 The R&E medical records staff will request the old health record from central HIR. If the previous medical record is on microfilm or electronically stored, this will be noted in the new record by Central HIR. (Portions of microfilmed or electronically stored records will be retrieved only upon request.)

10.2.2 The previous health record will be combined with the newly created record following the Documentation Standards Guidelines, unless the previous health record was microfilmed or electronically stored.

10.2.3 If the inmate has been assigned and transferred to an institution before the R&E medical records staff receives and combines the medical record, the old record will be forwarded to the inmate's newly assigned institution. The receiving institution will combine the new and the old records according to the Documentation Standard Guidelines. The receiving institution's medical staff will not document receipt of the record in the CRT until the "hard copy" is received (i.e., the "papers only" or temporary volume is not documented as received in the AMR.).

11. AUDITS: The Director of HIR or designee will conduct audits on at least an annual basis of a representative sample of health records at each institution. The Director of Health Information Resources will be responsible for visiting each institution annually and auditing the storage, security, and maintenance of inmate health records. A report of these visits will be written and distributed to the Director of Medical and Health Services, the Division of Operations, and the Warden.

12. DEFINITIONS:

Documentation Standards Committee refers to an interdisciplinary group of health professionals who will determine guidelines for documenting information in the medical/health record. The Committee will be responsible for approving standard abbreviations, documentation format (e.g., D.A.P., S.O.A.P.), structural documentation guidelines (e.g., black ink, yellow highlighters, proper error correction, etc.), new and revised forms, and required content to meet professional and legal standards. This Committee will be appointed by the Director of Medical and Health Services. (4-ACRS-4C-23, 3-4346)

Documentation Standards Guidelines refers to standards published in the Agency's Medical Directives Manual which provide guidelines for formatting and compiling an inmate's medical/health record as well as guidelines for the documentation within that record from the time the inmate enters/re-enters the SCDC until his/her release. The guidelines will be approved by the Director of Medical and Health Services and will be reviewed/updated regularly by the Documentation Standards Committee. A complete revision will be completed every three (3) years. (4-ACRS-4C-23, 3-4346)

Medical/Health Record/Automated Medical Record (AMR) refer to health information and medical forms (automated or hard copy) maintained by the Agency on each inmate admitted to the SCDC. The terms "health record," "medical record," and AMR are used interchangeably throughout this policy and related procedure.

Protected Health Information refers to all individually identifiable health information transmitted or maintained by a covered entity, hybrid entity, or business associate, regardless of form.

Transfer, for the purposes of this policy/procedure, refers to an inmate and/or his/her health record (or copies thereof) moving from one area of medical coverage to another, whether it be temporary (appointment, inpatient infirmary stay, court appearance, etc.) or permanent (reassignment to another institution).

SIGNATURE ON FILE

s/Jon E. Ozmint, Director

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